

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042691

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 375 Primary Registration District No. 6277 Registrar's No. 26

FILED NOV 15 1963

1. PLACE OF DEATH a. COUNTY WRIGHT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WRIGHT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN BOONE TWP		c. CITY OR TOWN NIANGUA R2	
Length of stay in 1b 29 YRS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) 7 MI SEAST	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First BEN Middle H Last WATTS			4. DATE OF DEATH Month NOV Day 8 Year 1963		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-28-1890	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months 9 Days 1 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MISSOURI	
12. CITIZEN OF WHAT COUNTRY U.S.A		13. FATHER'S NAME JOHN WATTS		14. NAME OF MOTHER OR WIFE MAHARA LASSLEY BRACIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO.		17. INFORMANT BRACIE WATTS NIANGUA R2	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Silicosis & Pulmonary Emphysema - 10 yrs		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)			
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cachexia		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 8:30 P. Month, Day, Year 11/8/63			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION NIANGUA R2	COUNTY WRIGHT STATE MO
21. I attended the deceased from 1950 to 11/8/63 and last saw him alive on Aug. 25, '63 Death occurred at 8:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE C.R. Macdonald M.D.	(Degree or title)	22b. ADDRESS Marshfield, Mo.	22c. DATE SIGNED 11/8/63
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11-13-1963	23c. NAME OF CEMETERY OR CREMATORY NATIONAL	23d. LOCATION (City, town, or county) (State) SPRINGFIELD MO
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24. FUNERAL DIRECTOR BARBER-EDWARDS MARSHFIELD	ADDRESS 11-13-1963	25. DATE RECD. BY LOCAL REG. 11-13-1963	26. REGISTRAR'S SIGNATURE Bonnie J. Jones
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

DATE AMENDED

VS 300
Rev. 4/59

1 1140

2 1140

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9 5230

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11

12 90-0

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961 61 AON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert Davis

Licensed Embalmer No. 5246

P. O. Address Mtn. Home, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.